Demographic characteristics

Geography: ZIP codes and ZCTAs

We report information by geography using modified ZIP Code Tabulation Areas (MODZCTA). It can be challenging to map data that are reported by ZIP Code. A ZIP Code doesn't actually refer to an area, but rather a collection of points that make up a mail delivery route. Furthermore, there are some buildings that have their own ZIP Code, and some non-residential areas with ZIP Codes.

To deal with the challenges of ZIP Codes, the Health Department uses ZCTAs which solidify ZIP codes into units of area. Often, data reported by ZIP code are actually mapped by ZCTA. The ZCTA geography was developed by the U.S. Census Bureau.

The modified ZCTA (MODZCTA) geography combines census blocks with smaller populations to allow more stable estimates of population size for rate calculation.

Information by geography reflect people's MODZCTA of residence at the time of reporting, and not the location of testing, diagnosing, or hospitalization.

Poverty groups

Neighborhood-level poverty groups were classified in a manner consistent with Health Department practices to describe and monitor inequities in health in NYC. Neighborhood poverty measures are defined as the percentage of people earning below the Federal Poverty Threshold (FPT) within a ZCTA, per the American Community Survey 2014-2018.

The standard cut-points for defining categories of neighborhood-level poverty in NYC are:

- Low: <10% of residents in ZCTA living below the FPT
- Medium: 10% to <20%
- High: 20% to <30%
- Very high: ≥30% residents living below the FPT

Age groups

The Health Department initially reported out data for the following age groups: 0-17, 18-44, 45-64, 65-74, and 75+ years. As of November 9, 2020, we updated the age groups to: 0-4, 5-12, 13-17, 18-24, 25-34, 35-44, 45-54, 55-64, 65-74, and 75+ years to provide more detail and granularity on age groups, especially with regard to children and young adults. For data on deaths, age groups 0-4, 5-12, and 13-17 are collapsed into 0-17 years due to low death counts in this population and to ensure protection of privacy.

Race and ethnicity

Race and ethnicity information is often missing in reportable disease surveillance. Information on race/ethnicity typically comes from electronic laboratory reports and unfortunately, race/ethnicity data are often missing in these reports. For the COVID-19 response, the Health Department has electronically imported aggregated data from partners such as hospitals, hospital systems, or Regional Health Information Organizations to improve the completeness of race/ethnicity data for people who are hospitalized. However, health records may also be missing race/ethnicity information. Additionally, the Health Department often investigates or imports race/ethnicity information for people who have died. However, this information is often incomplete or not immediately available because it can take a few days for the information to be entered into the electronic death registration system. Race/ethnicity information is typically collected by funeral directors from next of kin of the decedent.

The Health Department classifies race/ethnicity into the following mutually-exclusive categories: Asian/Pacific-Islander, Black/African-American, Hispanic/Latino, and White. Information on people identified as other categories, including Native American/Alaska Native or multi-racial, are not

provided in files showing race/ethnicity data. The Hispanic/Latino category includes people of any race, and all other categories exclude those who identified as Hispanic/Latino.

Differences in health outcomes among racial and ethnic groups are due to long-term institutional and personal biases against people of color. There is no evidence that these health inequities are due to personal traits. Lasting racism and an inequitable distribution of resources needed for wellness cause these health inequities. These include quality jobs, housing, health care and food, among others. The greater impact of the COVID-19 pandemic on people of color shows how these inequities influence health outcomes.